IN THE MATTER OF	*	**BEFORE THE MARYLAND**
MAURY FECHTER D.D.S.	*	**STATE BOARD OF**
Respondent	*	**DENTAL EXAMINERS**
License Number: 5494	*	**Case Number: 2013-126**

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CONSENT ORDER

Procedural Background

On December 23, 2014, the Maryland State Board of Dental Examiners (the "Board") issued and served on **MAURY FECHTER D.D.S** ("Respondent"), license number 5494, an **ORDER FOR SUMMARY SUSPENSION** of the Respondent's license to practice dentistry under Md. St. Gov't. Code Ann. § 10-226(c)(2)(2009 Repl. Vol.) The Board concluded that the public health, safety and welfare imperatively required emergency action based on the Respondent's violations of the Maryland Dentistry Act, Md. Health Occ. ("H.O.") Code Ann. § 4-315(a) as follows:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> (6) Practices dentistry in a professionally incompetent manner or in a grossly incompetent manner;
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession; and
>
> (28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's ["CDC"] guidelines on universal precautions...

On or about January 7, 2014, the Respondent affirmatively waived his right to appear before a quorum of the Board to show cause why the Order for Summary Suspension should not be continued and upheld. The Respondent also affirmatively elected to waive the issuance of Board-sanctioned Charges arising from the same circumstances.

Following his retention of an independent infection control consultant, the Respondent requested a Case Resolution Conference (the "CRC") before a subcommittee of the Board. The CRC, scheduled for May 7, 2014, provided the parties an opportunity to discuss a potential resolution of the Order for Summary Suspension. At the conclusion of the CRC, the parties agreed to enter into this Consent Order as a means of resolving the Order for Summary Suspension and Charges.[1]

FINDINGS OF FACT

A. Background

1. At all times relevant to the Order for Summary Suspension (the "Order"), the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about September 7, 1973, under License Number 5494. The Respondent's license was summarily suspended by the Board from December 23, 2014 to May 21, 2014.

[1] The Administrative Prosecutor and the Respondent, through counsel, have agreed that this Consent Order would obviate the need for filing Charges arising out of the same circumstances. This Consent Order does not affect or waive the Board's right to investigate allegations or file charges arising from a different complaint.

2. The Respondent was previously licensed to practice dentistry in New Jersey but allowed that license to expire on or about October 31, 1977. He was also licensed to practice dentistry in Delaware but allowed that license to expire on or about June 30, 1976.

3. At all times relevant to this Order, the Respondent operated as a solo practitioner, practicing general dentistry at three (3) private practice locations in the greater Baltimore, Maryland area, Office A at 6305 Belair Road, Office B at 700 N. Linwood Avenue and Office C at 8817 Belair Road.

4. On or about March 1, 2013, the Board received a complaint from the parent ("the Complainant") whose son had been a former patient of the Respondent from August 2, 2006 - January 25, 2013.

5. The Complainant alleged that prior to his last visit on January 25, 2013, her son had always been treated at Office A but on the visit in question, the Complainant was asked to bring her son to Office B.

6. Upon arrival, the Complainant observed that Office B had no central heating, was "unkempt" and "very dirty". During her son's routine prophylaxis and evaluation of mouth sores, the Complainant was "shocked by the condition of not only the office but also the exam room". She "couldn't believe her eyes" and expressed concern in her complaint that the instruments used in her son's mouth were not sterile.

7. Following its review of the complaint, the Board initiated an investigation. As part of its investigation, on or about April 12, 2013, the Board retained an independent infection control expert ("the Board Expert") to conduct an inspection of Office B.

8. On June 28, 2013, the Board Expert conducted an unannounced on-site inspection of Office B to determine whether the Respondent was in compliance with the

Maryland Dentistry Act (the "Act") and the Centers for Disease Control ("CDC")[2] guidelines for infection control in dental health-care settings. The Board Expert's evaluation and analysis was based on direct observations of patient treatment and instrument preparation, as well as discussions with the Respondent, his dental assistant(s) and receptionist.

9. The Board Expert issued a report on August 27, 2013, concluding that the general condition of Office B was dirty and unsanitary and that there was no evidence of routine sanitation. The Board Expert found twenty-eight (28) distinct violations of CDC guidelines for infection control.

10. On or about October 8, 2013, the Respondent notified the Board that he had closed Office B because someone "had stolen his air conditioning unit".

11. The Board's investigation revealed that the Respondent maintained two other locations in the greater Baltimore area. In early November 2013, the Board requested that the Board Expert conduct inspections of the Respondent's other locations, Offices A and C.

12. On November 12, 2013 the Board Expert conducted an unannounced on-site inspection of Office C to determine whether the Respondent was in compliance with the Act and CDC guidelines for infection control in dental health-care settings. The Board Expert's evaluation and analysis was based on direct observations of patient treatment and instrument preparation as well as discussions with the Respondent, his dental assistant(s) and receptionist.

[2] The Centers for Disease Control and Prevention ("CDC") is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines for dental offices which detail the procedures deemed necessary to minimize the chance of transmitting infection both from one patient to another and from the dentist, dental hygienist and dental staff to and from the patients. These guidelines include some very basic precautions, such as washing one's hands prior to and after treating a patient, and also sets forth more involved standards for infection control. Under the Act, all dentists are required to comply with the CDC guidelines which incorporate by reference Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Blood borne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

13. On November 14, 2013 the Board Expert conducted an unannounced, on-site inspection of Office A to determine whether the Respondent was in compliance with the Act and CDC guidelines for infection control in dental health-care settings. The Board Expert's evaluation and analysis was based on direct observations of patient treatment and instrument preparation as well as discussions with the Respondent, his dental assistant(s) and receptionist.

14. In her report issued on November 16, 2013 pertaining to Office A, the Board Expert concluded that the Respondent's ongoing accumulation of damaged dental equipment, use of unsterile instruments and absence of regular janitorial services resulted in a failure to maintain "a basic clean and sanitary facility in which to provide health services". She further concluded that the Respondent failed to implement and apply infection control protocols, resulting in potential risk to the health and safety of his patients and employees. A detailed summary of the Board Expert's findings regarding Office A is set fort*h infra*.

15. In her report issued on November 19, 2013 pertaining to Office C, the Board Expert concluded that multiple, serious violations were directly observed and identified. Again, the Respondent failed to maintain "a basic clean and sanitary facility in which to provide health services". Further, the Board Expert noted that basic concepts of infection control protocols..."mandated for two (2) decades... are not applied in this facility". A detailed summary of the Board Expert's findings regarding Office C is set forth *infra*.

A. <u>Reports of Board Expert</u>

<u>Office A</u>

16. The Board Expert found that the general office condition was dirty and unsanitary with layers of accumulated dust, dirt and debris. There was no evidence of routine environmental sanitation. In addition, the countertops of Respondent's three (3) treatment rooms, his dental lab and his sterilization room were all cluttered with unnecessary equipment, supplies and used instruments, preventing access to surfaces requiring routine disinfection.

17. The Board expert evaluated the Respondent's Heath and Safety Program. The Respondent was unable to produce necessary and required documentation of his Exposure Control Plan, employee training records, Hepatitis B vaccination records and post exposure forms. Despite his assurance to the Board Expert during her November 12, 2013 inspection of Office C, that all Health and Safety Program records for the entire practice were housed and available at Office A, the Respondent failed to provide written records, for annual safety evaluation, employee training records for the preceding three (3) years, or Hepatitis B vaccination records for himself and his staff.

18. The Respondent was observed handling paper products, charts and storage drawers while wearing contaminated gloves. These materials cannot be de-contaminated nor was any attempt made to employ disinfection techniques following his handling.

19. Although he was observed treating multiple patients, some of whose procedures produced blood and fluid splatter, the Respondent did not wash his hands "even once during the entire evaluation despite donning and removing treatment gloves multiple times."

20. Available utility gloves were torn and unusable.

21. The Respondent did not wear eye protection during treatment nor did he offer it to patients or employees.

22. The Respondent wore a mask hanging from one (1) ear and required prompting to place and remove the mask as appropriate.

23. The design of the sterilization area was substandard, leading to serious deficiencies in cleaning and sterilization. The sterilization area lacked a distinct and well-organized "clean" and "dirty" separation. Required sterilization of critical and semi-critical instruments including hand instruments, dental handpieces, endodontic files/reamers and burs, could not be verified.

24. The Board Expert observed handpieces and disposable tips for air/water syringes left in place on a dental unit bracket tray. The disposable tips were reused. Applicator tips were left on resin and syringes. Contaminated tips were reused on multiple patients.

25. Office spore testing was not adequately or properly performed to verify efficacy of the autoclave. Hand written records provided for a limited time frame, were incomplete and questionable as they were contradicted by controlled, objective testing obtained in October 2013 from a certified testing agency.

26. There was no routine maintenance or treatment of the dental unit waterlines thereby exposing every patient to potential biofilm contamination.

27. Food and dental supplies were improperly stored in a refrigerator that was housed in the sterilization room.

28. Numerous dental supplies including anesthetic needles and medications were expired. Expiration dates ranged from 2005-2013.

29. Birex surface disinfectant in an undated spray bottle was allegedly used to disinfect surfaces. Once activated, Birex has a maximum shelf life of 14 days.

30. Office A lacked the requisite waste removal documentation evidencing certified, routine waste removal during the preceding three (3) years. Medical waste containers were overfilled and located in areas exposed to patients. The Board Expert observed a sealed box of medical waste with visible evidence of water damage, thereby suggesting that timely disposal had not occurred.

31. Red sharps containers were overfilled with used needles and other sharps, beyond the fill line. Intact puncture resistant containers must be closed and sealed once the contents reach the visible fill line to avoid injuries and/or cross contamination to patients or employees.

32. The Respondent was unable to readily locate his CPR resuscitator mask. If necessary, neither the Respondent nor his staff had the ability to perform CPR without the risk of disease transmission.

33. Emergency medical supplies were not available and there was no designated eyewash station in the event of an eye injury or exposure incident.

34. Dental equipment was in a state of disrepair. Among other things, Operatory #3 had a broken cuspidor and water dispenser that leaked water onto the floor. Further, the dental unit in Operatory #2 had barrier shields used as a make-shift patch. Multiple safety hazards were also noted.

35. The Board's investigation revealed that a portion of the Respondent's office was sub-let to a tenant allegedly operating a massage therapy business. The Board Expert noted that the Respondent "seemed unconcerned that the arrangement allowed access to

his office space including patient records." Confidentiality of dental records was potentially compromised through the Respondent's failure to protect the privacy of his patient's health care information.

Office C

36. The Board Expert observed that the general condition of Office C was dirty and unsanitary. Carpeting used in the clinical areas including operatories/treatment rooms, precluded routine cleaning and disinfection following splatter of blood and/or saliva. Countertops of the dental lab, treatment rooms and sterilization area were covered with dirt, debris, equipment, supplies and used instruments. Thorough infection control, disinfection and sanitation were seriously compromised.

37. The Board Expert noted during her inspection of Office C that the autoclave sat precariously on a sagging, damaged countertop, with exposed particleboard partially covered with duct tape. Dirt, debris, loose instruments and dental materials had been placed on top of and on either side of the autoclave. The poorly supported countertop combined with the exposed spongy surface enhanced the risk of potential disease transmission from organism absorption. There was also a risk of potential collapse and damage to the autoclave.

38. The Board Expert further found that the dental units in Operatory # 1 and 3 were in disrepair. She observed treatment supplies falling from the brackets onto the floor. The Respondent retrieved the supplies from the contaminated floor and returned them to patient care. Bloodstains were observed on the bracket tray and support arms of the dental unit in Operatory #1.

39. The Board Expert observed in her inspection of Office C, identical or substantially similar violations of the Act and CDC guidelines as found during her inspection of Office A. With respect to Office C, Findings of Fact, Para. #s 16-32, *supra,* are incorporated herein by reference.

40. In addition to Finding of Fact, Para. # 23, *supra,* spore test capsules, disinfectants and dental supplies were also expired. Expiration dates ranged from 2004-2013.

41. Following notice of the Order for Summary Suspension, the Respondent implemented some, but not all, safety and infection control protocols consistent with CDC guidelines. He further retained the services of an infection control consultant (the "Respondent's expert") to conduct an inspection of the Respondent's offices.

42. On March 8, 2014 the Respondent's expert issued a report regarding her March 6, 2014 inspection of Office A. On March 14, 2014, the Respondent's expert issued a report regarding her inspection of Office C. On the respective dates of those inspections, the Respondent's expert found six (6) continuing violations of CDC and OSHA guidelines at Office A, and twelve (12) continuing violations at Office C. She further noted that she was unable to evaluate the Respondent's clinical compliance due to the continued summary suspension of his license to practice dentistry. The Respondent's expert made recommendations to the Respondent to assist him in achieving satisfactory compliance with the Act, and CDC/OSHA guidelines.

43. The Respondent's expert conducted follow-up inspections of Offices A and C on May 2, 2014, during which she found that the Respondent's general office and administrative violations had been corrected. She noted that she was still unable to assess

the Respondent's clinical, direct patient-care because his license continued to be subject to the Board's December 23, 2013 Order for Summary Suspension.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that at the time of the issuance of the Order for Summary Suspension, the Respondent constituted an imminent threat to the public, and that the public health, safety or welfare imperatively required emergency action in this case, pursuant to Md. State Govt. Code Ann. § 10-226(c)(2)(2009 Repl. Vol.)

The Board further concludes as a matter of law that the Respondent, practiced dentistry in a professionally incompetent manner or in a grossly incompetent manner in violation of H.O. §4-315(a)(6); behaved dishonorably or unprofessionally, or violated a professional code of ethics pertaining to the dentistry profession, in violation of H.O. § 4-315(a)(16); and except in an emergency or life threatening situation where it is not feasible or practicable, failed to comply with Centers for Disease Control's guidelines on universal precautions in violation of H.O. § 4-315(a)(28).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 21st day of May 2014, by a majority of the quorum of the Board, hereby

ORDERED that upon the Board's receipt of documentation that the Respondent has formally retained the services of an independent Board approved CDC consultant, the Board will **LIFT** the **ORDER OF SUMMARY SUSPENSION** of the Respondent's license to practice dentistry issued on December 23, 2013; and it is further

ORDERED that the Respondent's license to practice dentistry shall be immediately **SUSPENDED** for a period of **TWO (2) YEARS, SUSPENSION STAYED**, for the purpose of allowing the Respondent a "wind up" period during which he may make the necessary administrative and practical arrangements to re-open one (1) of his practice locations, either Office A or C, and it is further

ORDERED that during the "wind-up" period, the Respondent **may not** provide any patient care, treatment, advice or recommendations. The Respondent may hire necessary office staff, contact third party payers, contact patients in order to schedule appointments, retain the services of a board-approved infection control consultant, contract with dental equipment service providers, and otherwise engage in operational and administrative tasks necessary for the re-opening of his office locations, and it is further

ORDERED that upon written notification to the Board of his first day of scheduled patient care, confirmation that the Board approved infection control expert is available to observe and evaluate the Respondent for the entire "first day", and notification of which practice location shall be reopened first, the Board notify the Respondent, in writing, that he is approved to provide patient care at a designated practice location, under the direct monitoring and supervision of the Board approved expert, and it is further

ORDERED that in addition to monitoring and supervising the Respondent's patient care on his first day at the designated practice location, the Board-approved consultant shall oversee a second, full day of patient care within seven (7) days after the Respondent's license to provide patient care is reinstated, in order to evaluate the Respondent and his staff regarding compliance with the Act and infection control guidelines. The second day of oversight and supervision shall be unannounced. If

necessary, the consultant shall further train the Respondent and his staff in the proper implementation of infection control protocols. The consultant shall be provided with copies of the Board file, this Consent Order, all prior inspections and any and all documentation deemed relevant by the Board, and it is further

ORDERED that the Respondent shall be placed on **PROBATION** for a period of **THREE (3) YEARS** from the date of the Board's execution of this Consent Order under the following terms and conditions:

1. No sooner than **ninety (90) days** after the Respondent's first day of patient care at the designated practice location, he may re-open his second practice location ("Office 2") for direct patient care. At least seven (7) days prior to his reopening of Office 2, the Respondent shall notify the Board and the Board consultant, in writing, of his first day of scheduled patient care for Office 2.

2. On or before the **fifth day** of each month, the Respondent shall provide to the Board a listing of his regularly scheduled days and hours for patient care.

3. The Respondent shall be subject to **monthly,** unannounced onsite inspections of any and all practices locations, by the Board approved consultant, during the **first six (6) months** of his three (3) year probationary period. If there are no documented violations noted by the consultant during the initial six (6) month period of probation, the Respondent shall thereafter be subject to unannounced, **quarterly onsite inspections for eighteen (18) months.** If there are no documented violations noted by the consultant, the Respondent shall be subject to **two (2)** unannounced, onsite inspections during the **third year** of his probationary period.

4. The consultant or Board approved agent shall provide reports to the Board within **ten (10) days** of the date of each inspection and may consult with the Board regarding the findings of the inspections. A finding by the Board indicating that the Respondent or his practice is not in compliance with the CDC guidelines shall constitute a violation of this Order and may, in the Board's discretion, be grounds for summarily suspending the Respondent's license. In the event that the Respondent's license is suspended under this provision, he shall be afforded a Show Cause Hearing before the Board to show cause why his license should not be suspended.

   At the Board's discretion, the Respondent may also be subject to random, unannounced inspections at any time during the probationary period. A finding by the Board indicating that the Respondent, at either or both of his

office locations, is not in compliance with the CDC guidelines shall constitute a violation of this Order and shall be grounds for **IMMEDIATE, ACTIVE SUSPENSION** of the Respondent's license to practice dentistry for **TWO (2) YEARS.**

5. Respondent shall, at all times, practice dentistry in accordance with the Act and further comply with CDC guidelines, including Occupational Safety and Health Administration's ("OSHA") for dental healthcare settings.

AND IT IS FURTHER ORDERED that during the first and second year of his probationary term, the Respondent shall successfully complete a **Board approved course** in **INFECTION CONTROL**, in addition to successful completion of all continuing education requirements for renewal of his license, including but not limited to infection control requirements. No part of the training or education that the Respondent receives in order to comply with this Consent Order shall be applied to his required continuing education credits, and it is further

ORDERED within twelve (12) months of the execution of this Order, the Respondent shall successfully complete a **Board-approved course in *CULTURAL COMPETENCY*** with a specific focus on appropriate standards for care and treatment of **culturally, economically and racially diverse populations,** and it is further

ORDERED that the Respondent shall at all times cooperate with the Board, any of its agents or employees, and with his consultant, in the monitoring, supervision and investigation of the Respondent's compliance with the terms and conditions of this Consent Order, and it is further

ORDERED that the Respondent shall be responsible for all costs incurred under this Consent Order; and it is further

ORDERED that after a minimum of three (3) years from the effective date of reinstatement of his license, the Respondent may submit a written petition to the Board

requesting termination of probation without conditions or restrictions. After consideration of the petition, the probation may be terminated through an Order of the Board. The Board shall grant termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending investigations or outstanding complaints similar to the charges; and it is further

ORDERED that if Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for a show cause hearing before the Board, or opportunity for an evidentiary hearing before an Administrative Law Judge at the Office of Administrative Hearings if there is a genuine dispute as to the underlying material facts, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Dental Practice Act, including an additional probationary term and conditions of probation, reprimand, suspension, revocation and/or a monetary penalty, said violation of probation being proved by a preponderance of the evidence; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-601 *et seq.* (2009 Repl. Vol.)

05/21/2014
Date

Ngoc Q. Chu, D.D.S.
President
Maryland State Board of Dental Examiners

CONSENT

I, Maury Fechter D.D.S., License No. 5494, by affixing my signature hereto, acknowledge that I have consulted with counsel, Alan Bussard, Esquire, and knowingly and voluntarily elected to enter into this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I am aware that I am entitled to a formal evidentiary hearing, pursuant to Md. Health Occ. Code Ann. § 4-318 (2009 Repl. Vol. & 2013 Supp.) and Md. State Gov't Code Ann §§ 10-201 *et seq.* (2009 Repl. Vol. & 2013 Supp.).

I accept the validity and enforceability of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections as provided by law. I am waiving those procedural and substantive protections.

I voluntarily enter into and agree to abide by the terms and conditions set forth herein as a resolution of the Order of Summary Suspension issued against me. I further agree that I waive my right to have Charges filed against me arising from the same circumstances. I waive any right to contest the Findings of Fact and Conclusions of Law and I waive my right to a full evidentiary hearing, as set forth above, and any right to appeal this Consent Order or any adverse ruling of the Board that might have followed any such hearing.

I sign this Consent Order voluntarily, without reservation, and I fully understand and comprehend the language, meaning and terms of this Consent Order.

5/19/2014
Date

Maury Joseph Fechter DDS
Maury Fechter D.D.S.
Respondent

Read and approved:

Alan Bussard, Esquire,
Attorney for the Respondent

Baltimore County, State of Maryland
The foregoing instrument was acknowledged before me
this 19 day of May, 2014
by Maury Fechter DDS.
Notary Public
TAMARA JEAN PROUDFOOT
My commission expires November 16, 2015

NOTARY

STATE OF MARYLAND
CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 19 day of May, 2014 before me, a Notary Public of the State and County aforesaid, personally appeared before me Maury Fechter D.D.S. License Number 5494 and gave oath in due form of law that the foregoing Consent Order was his voluntary act and deed.

AS WITNESS, my hand and Notary Seal.

Notary Public

My commission expires: 11-16-2015.

11-16-2015